UNITEDHEALTHCARE PPO MEDICAL PLAN
FOR EMPLOYEES – CALENDAR YEAR 2008

BENEFITS	UNITEDHEALTHCARE PPO – 2008
Annual Out-of-Pocket Maximum	**In Network: $1,250 / $2,500** **Out-of-Network: $3,500 / $7,000**
Deductible – In Network **Deductible – Out-of-Network**	**In Network: $300 / $600** **Out-of-Network: $400 / $800**
Coinsurance – In Network **Coinsurance – Out-of-Network**	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**
Office Visit / Urgent Care	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**
Preventive Care	**In Network: Some at 100%** **Out-of-Network: 60% / 40% coinsurance**
Laboratory and X-Ray Services	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**
Chiropractic Care	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance** **Visits: 20-visits per year limit, In and Out-of-Network combined.**
Prescription Drugs	**Express Scripts, Inc.** **Retail: (for a 30-day supply)** **Generic $ 7** **Brand name preferred $25** **Brand name non-preferred $40** **No deductible** **Mail Order: (for a 90-day supply)** **Generic $14** **Brand name preferred $50** **Brand name non-preferred $80** **No deductible**
Inpatient Hospital	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**
Outpatient Hospital	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**
Maternity Services	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**
Emergency Room Care **(Hospital)**	**$75 co-pay per visit, plus 80% / 20% coinsurance**
Ambulance	**80% / 20% coinsurance**
Durable Medical Equipment	**In Network: 80% / 20% coinsurance** **Out-of-Network: 60% / 40% coinsurance**

Note: Deductibles apply to all services unless otherwise stated. This is a brief summary only; not the contract. For more detailed information, refer to the summary plan description. (Note: 2008 Out-of-Pocket Maximums and Deductibles do not reflect the summary plan description.)

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BENEFITS	UNITEDHEALTHCARE PPO – 2008
Rehabilitation Services	**In Network:** **Outpatient 80% / 20% coinsurance** **Visits: Up to 30 visits, per condition, per year; 20 for cardiac and pulmonary.** **Inpatient 80% / 20% coinsurance** **Visits: 60 days per condition, per year.** **Out-of-Network:** **Outpatient 60% / 40% coinsurance** **Visits: Up to 30 visits per condition, per year; 20 for cardiac and pulmonary.** **Inpatient 60% / 40% coinsurance** **Visits: 60 days per condition, per year.**
Mental Health Services	**Outpatient:** **In Network: $15 individual; $5 group** ***Visits: 60-visit limit.** **Out-of-Network: 50% coinsurance** ***Visits: 25-visit limit.** **Inpatient:** **In Network: 100% paid** ***Visits: 60 days per year.** **Out-of-Network:** **Mental health: 40%, up to 20 days per calendar year.** ***Mental Health and Chemical Dependency visits combined.**
Chemical Dependency	**Outpatient:** **In Network: $15 individual; $5 group** ***Visits: Maximum of 60 visits per year.** **Out-of-Network:** ***Visits: Up to 25 visits per year.** **Inpatient:** **In Network: 100% / 0%** ***Visits: 60 days per year.** **Out-of-Network: 50%** ***Visits: 20 days per year; maximum $5,000 per year.** ***Mental Health and Chemical Dependency visits combined.**
Vision Exam **Optical Hardware**	**In Network: Spectera Vision – Annual exam: $10 co-pay.** **Out-of-Network: Annual exam: 85% of contracted charges. Maximum reimbursement in a calendar year is $165 for exam and hardware combined.** **In Network: Spectera Vision – Lenses every 12 months: $10 co-pay. Frames every 24 months.** **Out-of-Network: Frames and lenses every other year Up to $165 total, including exam.**

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